



The California Managed Risk Medical Insurance Board
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November 9, 2007

R-2-07

ADVANCE NOTICE OF INTENT TO FILE EMERGENCY REGULATIONS

This notice is sent in accordance with Government Code Section 11346.1(a) (2), which requires that State of California agencies give a five working day advance notice of intent to file emergency regulations with the Office of Administrative Law (OAL). The Managed Risk Medical Insurance Board ("Board") intends to file an Emergency Rulemaking package with the Office of Administrative Law (OAL), providing authority for waiting lists and disenrollments in the Healthy Families Program (HFP). As required by subdivisions (a)(2) and (b)(2) of Government Code Section 11346.1, this notice appends the following: (1) the specific language of the proposed regulation and (2) the Finding of Emergency, including specific facts demonstrating the need for immediate action, the authority and reference citations, the informative digest and policy statement overview, attached reports, and required determinations.

The Board plans to file the Emergency Rulemaking package with OAL at least five working days from the date of this notice. If you would like to make comments on the Finding of Emergency or the proposed regulations (also enclosed), they must be received within five calendar days of the Board's filing at OAL by both the Board and the Office of Administrative Law. Responding to comments at this point in the process is strictly at the Board's discretion.

Comments should be sent simultaneously to:

Managed Risk Medical Insurance Board
Attn: JoAnne French, R-1-07
1000 G Street, Suite 450
Sacramento, CA 95814

And

Office of Administrative Law
300 Capitol Mall, Suite 1250
Sacramento, CA 95814

Please note that this advance notice and comment period is not intended to replace the public's ability to comment once the emergency regulations are approved. The Board

will hold a public hearing and 45-day comment period within the 180 day certification period following the effective date of the emergency regulations.

Please contact JoAnne French at 916-327-7978 or jfrench@mrmib.ca.gov if you have any question concerning this Advance Notice.

Enclosures

FINDING OF EMERGENCY

At its November 5, 2007 meeting, the Managed Risk Medical Insurance Board (MRMIB) found that an emergency exists and that the immediate adoption of the attached proposed regulations is necessary to avoid serious harm to the public peace, health and safety, or general welfare. A copy of the Finding of Emergency adopted by the Board is attached.

SPECIFIC FACTS DEMONSTRATING THE NEED FOR IMMEDIATE ACTION

MRMIB operates the Healthy Families Program (HFP). HFP provides health insurance for more than 830,000 low-income children whose family incomes are at or below 250% of the federal poverty level net of applicable deductions and who are ineligible for Medi-Cal because of their family incomes exceed Medi-Cal income eligibility. (Insurance Code section 12693 et seq.) By statute, the Board must maintain enrollment and expenditures to ensure that expenditures do not exceed amounts available. If sufficient funds are not available to cover the estimated cost of program expenditures, the Board must institute appropriate measures to limit enrollment. (Insurance Code section 12693.21(n).)

Approximately two-thirds of the funding for HFP is provided by the federal State Children Health Insurance Programs (SCHIP). (42 U.S.C. 1397aa et seq.) The federal reimbursement is known as "federal financial participation." The authorization for SCHIP was scheduled to expire on September 30, 2007. In late September, Congress passed, and the President signed, a continuing resolution to continue SCHIP and provide the states with the same, or "flat," level of funding as the previous federal fiscal year (FFY).¹ (House Joint Resolution 52.) However, the continuing resolution provided that these SCHIP funds are available to states only until November 16, 2007. Unless Congress and the President act, there will be no new federal funds for the HFP program past November 16, 2007. Even if Congress and the President act to make the remainder of the flat federal funding available for the FFY 2008, HFP will experience a \$266 million shortfall because of continuing new enrollment and inflation. If no further federal funding is appropriated past November 16, the consequences for the program will become even more dire.

The flat funding provided by the current continuing resolution, the lack of a federal appropriation beyond November 16, and the lack of stable federal funding for FFY 2008 calls for the immediate action of adopting the proposed regulations to enable the Board to meet its statutory obligations: (1) to ensure that expenditures do not exceed amounts available and (2) if sufficient funds are not available to cover the estimated cost of program expenditures, to institute appropriate measures to limit enrollment. (Ins. Code sec. 12693.21(n).) Furthermore, under the HFP enabling statute, the program can be implemented

¹ The federal fiscal year is from October 1 to September 30.

only if, and to the extent that, federal financial participation through SCHIP is available. (Insurance Code section 12693.96(c).) Without the adoption of the proposed regulations, there is no regulatory authority for the Board to limit enrollment.² Thus, the immediate adoption of the attached proposed regulations is necessary to avoid serious harm to the public peace, health and safety or general welfare by enabling the Board to discharge its statutory duties.

These circumstances require that the Board prepare to either limit enrollment as soon as practicable or entirely shut down the program in June 2008, thereby disenrolling more than 830,000 children. The Board has determined that the proposed regulations – providing for the establishment of a waiting list for new applications for new children and, if the waiting list does not sufficiently limit expenditures, disenrollment of subscriber children at Annual Eligibility Review – are appropriate measures to limit enrollment.

The sooner that actions are taken to limit enrollment, the fewer children will be affected. HFP makes monthly capitation payments to health plans for each enrolled child. If the Board can avoid capitation payments for some children sooner, more children will be able to remain enrolled. For illustrative purposes only, if a subscriber child were disenrolled effective February 1, the program would save eight months of capitation payments in the FFY. By contrast, if a subscriber child were disenrolled effective June 1, the program would save only four months of capitation payments. Thus, two subscriber children would have to be disenrolled to realize the same savings.

As a practical matter, the earliest date that MRMIB can establish a waiting list or disenroll children subscribers would be January 1, 2008. Under the Office of Administrative Law governing statutes concerning the timeframe for adopting emergency regulations, from the date of the Board adopted the emergency finding, it could take approximately thirty (30) days for the proposed regulations to become effective. In addition, the program would have to make operational changes to establish a waiting list or disenroll subscriber children and, under the terms of the proposed regulations, the Board would have to make additional formal findings of financial necessity. Depending on level of federal funding that HFP receives, further delays in implementing the proposed regulations would adversely impact more children.

AUTHORITY AND REFERENCE CITATIONS

Authority: Insurance Code section 12693.21

² The adoption of the proposed regulations would not by itself establish a waiting list or disenroll subscriber children. Further Board actions would be required as set forth in the proposed regulations. The adoption would only provide for the process to limit enrollment as circumstances dictate.

Reference: Insurance Code section 12693.21; Insurance Code section 12693.96(c).)

INFORMATIVE DIGEST AND POLICY STATEMENT OVERVIEW

Existing Law: MRMIB operates HFP to provide health insurance for low-income children. Approximately two-thirds of the program is funded through the federal SCHIP program. The enabling HFP statute requires the Board to maintain enrollment and expenditures to ensure that expenditures do not exceed amounts available and, if sufficient funds are not available to cover the estimated cost of program expenditures, the program must institute appropriate measures to limit enrollment. The proposed regulations would provide regulatory authority for the Board to establish waiting lists or disenroll children subscribers at their Annual Eligibility Reviews. The present regulations do not provide for specific measures to limit enrollment.

A summary of the proposed regulations' effect on existing law and regulations is as follows:

2699.6603. Early Applications.

Section 2699.6603 describes the process through which applicants may apply early to the HFP. The text of this section was not changed, but the section was re-numbered to 2699.6602 to accommodate for the addition of subsequent sections.

2699.6603. Board Determinations.

A new section 2699.6603 would be added.

Subsection 2699.6603(a) would establish the authority to create a waiting list if the Board deems necessary to operate the program within financial means.

Subsection 2699.6603(b) would establish the authority to disenroll children at Annual Eligibility Review if the Board deems that limiting new enrollment is not enough to operate the program within financial means. Section 2699.6603(b) specifies that children will not be disenrolled at Annual Eligibility Review unless a waiting list has been established and the program is not currently enrolling new children on the basis of applications or Add-A-Person forms.

Subsection 2699.6603(c) would establish the authority for the Executive Director to discontinue Annual Eligibility Review disenrollments if he or she determines that funds exist to cover the estimated cost of program expenditures of all eligible subscriber children, i.e., those already enrolled.

Subsection 2699.6603(d)(1) would provide that if the Executive Director determines that, in addition to sufficient funds for all eligible subscriber children, sufficient funds available to cover the estimated cost of program expenditures for some or all children on the waiting list, the program will review application for children on the waiting list in the order of their effective dates on the waiting list.

Subsection 2699.6603(d)(2) would provide that if the Executive Director determines that sufficient funds are available to cover the estimated costs of program expenditures, the program will cease a waiting list after processing all applications, including Annual Eligibility Reviews and Add-A-Person applications.

2699.6604. Waiting List for Children.

Section 2699.6604 would be added.

Subsection 2699.6604(a) would provide that, if the program has established and is operating a waiting list, applications or Add-A-Person forms for new enrollment will be placed on the waiting list in the order that the applications and forms were received. A child's effective date on the waiting list would be the date on which the program received the child's application. An eligibility determination will not be made until the Executive Director has made a determination pursuant to Section 2699.6603(d) and the applicant provides all supporting documentation.

Subsection 2699.6604(b) would provide that if the Board makes a finding pursuant to section 2699.6603(b), each subscriber child enrolled at Annual Eligibility Review will be placed on the waiting list with his or her disenrollment date as the effective date on the waiting list.

Subsection 2699.6604(c) would provide that when the program places a child on the waiting list, the applicant will be notified in writing.

Subsection 2699.6604(d) would provide that, when the Executive Director determines that there is funding available for at least some of the children on the waiting list, these children will be enrolled in the program as specified in subsections 2699.6604(d)(1) and (2).

Subsection 2699.6604(d)(1)(A) would be added to provide that the program will first enroll those children who were placed on the waiting list because they were disenrolled at their Annual Eligibility Review. The program will enroll these children in the order of their effective dates on the waiting list, starting with those who have the earliest effective date.

Subsection 2699.6604(d)(1)(B) would provide that, if and when there are no remaining children who are on the waiting list because they were disenrolled at Annual Eligibility Review, the program will, to the extent that sufficient funds are available, enroll additional wait-listed children in the order of their effective dates on the waiting list, starting with those who have the earliest effective date.

Subsection 2699.6604(d)(2) would provide that when sufficient funds are available to enroll a child based on the child's placement on the waiting list, the program will provide the applicant with written notification. In the notice, the program will request any necessary information to determine eligibility including any updates to information that is no longer current. The program will then establish eligibility.

2699.6605. Initial Review of Application for Child-linked Adults

Section 2699.6605 describes the process through which Child-Linked adults are enrolled in the HFP. The text of this section was not changed. The section would re-named to clarify that these regulations apply only to adults, not children, who are addressed in the previous section. (The HFP child-linked adult expansion was not implemented because the statute and regulations made it contingent on appropriation and it was never funded.)

2699.6608 Enrollment of AIM Infants.

Section 2699.6608 describes the process in which AIM infants are enrolled into the program. The proposed regulations would amend Subsection 2699.6608(a) to specify that AIM infants are to be enrolled in to the program without application and therefore are not subject to a waiting list. This is merely a clarification of existing law, not a substantive change; pursuant to the HFP statute, AIM babies are automatically enrolled and therefore they do not file applications. (Ins. Code sec. 12693.70(a)(6)(A)(ii).) The clarification is important in order to avoid any misunderstanding of the waiting list provision; specifically, it avoids any confusion to the effect that AIM infants eligible for automatic enrollment into HFP might be placed on a waiting list, The clarification does not change existing law.

The version of the waiting list/disenrollment regulation presented to the MRMIB board at its November 5 meeting inadvertently amended the version of Section 2699.6608 that was in effect prior to July 31, 2007; the proposed regulation should instead have amended the version of Section 2699.6608 that took effect July 31, 2007 to implement the 2006 health trailer bill (AB 1807). The version staff brought to the board November 5 added the words "without application" after the phrase "shall be enrolled"

in subsection (a) of Section 2699.6608 but inadvertently amended the out-of-date version of subsection (a).

To remedy this clerical error and avoid nullifying the existing regulation, the waiting list/disenrollment regulation that MRMIB is filing with the Office of Administrative law instead amends the current version of Section 2699.6608. The corrected version of the waiting list/disenrollment regulation adds the words “without application” after the phrase “shall be enrolled” both in subsection (a) and in subsection (b). This is because the July 31, 2007 regulation split subsection (a) of Section 2699.6608 into two subsections, (a) and (b), to separate infants born before July 1, 2007 from those born on or after July 1, 2007. This is a technical correction and does not have any substantive impact on either the existing regulation or the waiting list/disenrollment regulation adopted by the MRMIB board on November 5.

2699.6611. Disenrollment.

Section 2699.6611 describes the various reasons for which a child can be disenrolled from the HFP. Subsection 2699.6611(a)(2) would be added to provide that subscriber children will be disenrolled if the Board makes a finding pursuant to Section 2699.6603(b).

Subsections 2699.6611(a)(2) through (13) and other sections within subsections (d) through (n) would be re-numbered to accommodate the addition of Subsection 2699.6611(a)(2).

Subsection 2699.6611(b)(2) would be added to provide that, prior to disenrolling a subscriber pursuant to (a)(2), the program will provide written notification to the application no less than fifteen (15) days prior to disenrollment. In addition, the notice will clearly indicate the reason for the disenrollment and the effective date of disenrollment. The numbering of the subsection would be modified.

The waiting list/disenrollment regulations adopted by the MRMIB board November 5 amend the version of Section 2699.6611 that incorporates the text of emergency regulations adopted by the board at its September 19, 2007 meeting to implement the 2007 health trailer bill (AB 203). These regulations, for which AB 203 provided deemed emergency authority and exemption from Office of Administrative Law review (Section 101 of AB 203), have not yet been filed with the Office of Administrative Law. MRMIB intends to publicly notice and file the trailer bill regulations simultaneously with the waiting list/disenrollment regulations. Therefore, by the time the waiting list/disenrollment regulations take effect, the correct version of Section 2699.6611 should be in effect.

2699.6625. Annual Eligibility Review for Subscribers.

Section 2699.6625 describes the Annual Eligibility Review process for HFP subscribers. The proposed regulations would amend Subsection 2699.6625(e) to reflect that eligibility determinations will also be made pursuant to 2699.6611(a)(2).

Policy Statement: The objective of the proposed regulations is to provide the Board with regulatory to limit enrollment, thereby allowing it to discharge its statutory duty of ensuring that expenditures do not exceed program costs.

TECHNICAL, THEORETICAL, AND EMPIRICAL STUDY or REPORT

1. "States with Projected SCHIP Shortfalls in 2008"; Agenda Item 6.a., MRMIB 10/24/07 meeting.
2. "The Possible Impact upon California of Reduced SCHIP Funding," California HealthCare Foundation, September 26, 2007"; Agenda Item 6.a(3), MRMIB 10/24/07 meeting.

DETERMINATIONS

The Proposed Substantial differentiation from existing comparable Federal Regulation or Statute: No.

Mandates on Local Agencies or School Districts: None.

Mandate Requires State Reimbursement Pursuant to Part 7 (commencing with section 17500) of Division 4 of the Government Code: None.

Costs to Any Local Agency or School District that Requires Reimbursement Pursuant to Part 7 (commencing with section 17500) of Division 4 of the Government Code: None.

Non-discretionary Costs or Savings Imposed on Local Agencies: None.

Costs or Savings to Any State Agency: None.

Costs or Savings in Federal Funding to the State: The adoption of the regulations, which only provides for a framework for limiting enrollment, would not affect costs or savings in federal funding to the state. Any action actually taken by the Board to establish a waiting list or to disenroll subscriber children would be the result of federal action or inaction in order to accommodate the level of federal financial participation in HFP expenditures.

States with Projected SCHIP Shortfalls in 2008

Shortfall State (CRS) ³	Projected Shortfall in Millions (CRS)	2008 Month of Shortfall (CRS)	Children Ever Enrolled FY 2006 (CMS) ⁴	Enrollment June 2006 (KFF) ⁵
Alaska	\$11.8	March	22,227	9,582
Arkansas	\$16.6	August	3,440	67,170
California	\$342.5	June	1,391,405	*860,888
Georgia	\$199.9	March	343,690	257,212
Illinois	\$253.2	March	316,781	151,253
Iowa	\$35.8	March	49,575	36,286
Louisiana	\$3.9	September	142,389	107,777
Maine	\$17.3	March	31,114	14,705
Maryland	\$88.7	March	136,034	101,552
Massachusetts	\$157.3	March	190,640	75,019
Minnesota	\$41.6	April	5,343	2,229
Mississippi	\$55.8	April	83,359	60,457
Missouri	\$44.2	May	106,577	61,097
Nebraska	\$14.1	May	44,981	23,194
New Jersey	\$191.1	March	120,884	127,525
North Carolina	\$49.5	June	247,991	144,148
North Dakota	\$4.9	May	6,318	4,454
Ohio	\$11.9	September	218,529	142,374
Oklahoma	\$21.5	July	116,012	58,731
Rhode Island	\$44.1	March	25,492	12,412
South Dakota	\$0.7	September	14,584	11,323

³ Peterson, Chris. *Provision of Temporary FY2008 SCHIP Allotments*. CRS Report for Congress. Congressional Research Service. Order Code RS22739. October 12, 2007

⁴ Centers for Medicare and Medicaid Services. FY 2006 Annual Enrollment Report. <http://www.cms.hhs.gov/NationalSCHIPPolicy/downloads/FY2006StateTotalTable.pdf>. March 21, 2007

⁵ Vernon Smith et al., *SCHIP Turns 10: An Update on Enrollment and the Outlook on Reauthorization from the Program's Directors*. Kaiser Commission on Medicaid and the Uninsured. May 2007

* Note: A review of enrollment data from the Managed Risk Medical Insurance Board's records show a combined enrollment for Healthy Families Program and Access for Infants and Mothers was 773,797 in June 2006. Medi-Cal's records show a combined total of approximately 108,000. This would result an enrollment estimate of 881,797 for California in June 2006.



The Possible Impact upon California of Reduced SCHIP Funding

Prepared for
California HealthCare Foundation

Prepared by
Peter Harbage and Lisa Chan-Sawin
Harbage Consulting

September 26, 2007

Acknowledgments

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About the Authors

Peter Harbage is president of Harbage Consulting, a Sacramento-based health policy firm where Lisa Chan is a director. Hilary Haycock, a consultant to Harbage Consulting, provided comments on a draft of this paper.

About the Foundation

The California HealthCare Foundation, based in Oakland, is an independent philanthropy committed to improving California's health care delivery and financing systems. Formed in 1996, our goal is to ensure that all Californians have access to affordable, quality health care. For more information about CHCF, visit us online at www.chcf.org.

Introduction

After ten years of operation, the State Children's Health Insurance Program (SCHIP) now provides insurance to about 7 million people in the United States through a federal-state partnership.¹ Congress and the President are wrestling over how best to redesign the program, which was created by the Balanced Budget Act of 1997, and how much new funding should be made available. At the end of this month, no new federal dollars will be dedicated to SCHIP unless new budget authority is enacted. Without new dollars, SCHIP programs around the country are put in financial jeopardy, including the coverage of 1 million California children and pregnant women.²

SCHIP dollars in California support beneficiaries in several programs, including:³

- 832,000 children in Healthy Families, a non-Medicaid SCHIP expansion program.
- 242,000 children enrolled in Medi-Cal related programs.
- 8,400 pregnant women enrolled in Access for Infants and Mothers (AIM).⁴

While there appears to be a Congressional compromise on SCHIP, President Bush has threatened to veto any SCHIP approach that does not conform to his own proposal.⁵ This analysis examines the impact of various funding scenarios on California's SCHIP-funded programs for Federal Fiscal Year (FFY) 2008, which begins on October 1. The analysis presumes that:

1. No new SCHIP dollars are allotted to states in FFY2008;
2. A "continuing resolution" provides flat funding of SCHIP dollars to states in FFY2008 at the FFY2007 funding levels; and
3. Interim monthly funding is approved to carry the program for two months at the FFY2007 levels, followed by a new funding structure.

The analysis also assumes that no changes are made to California's SCHIP-funded programs that might lower costs and thereby extend the time a program could operate. For example, in response to reduced funding, the state could choose to constrain enrollment (by instituting an enrollment cap), pare down benefits, or raise premiums. However the state has so far given no indication which, if any, of these steps might be taken.

Estimated FFY2008 Federal Funds

Gauging the possible impact of the different funding scenarios requires tabulating how much federal money California can expect to receive and comparing it with the state's estimated expenditures. The FFY2008 funding level will be determined by three funding streams:

- The federal allotment;
- "Carryover funds" based on the amount of dollars California did not spend from the FFY2006 and FFY2007 allotments; and
- "Redistribution funds" based on dollars allotted under current law to California from states that did not spend their full FFY2005 allotment.

Table 1: Possible Federal SCHIP Funds Available in FFY2008

SCHIP Funding Streams	No New Federal Dollars	Flat Funding
FFY2008 Federal Allotment: ⁶	\$0	\$790,789,213
FFY2007 Carryover Funds: ⁷	\$166,000,000	\$166,000,000
FFY2008 Redistribution Funds: ⁸	\$17,649,000	\$17,649,000
Total Federal Funds Available:	\$183,649,000	\$974,438,213

As shown in Table 1, California would have \$184 million federal SCHIP dollars if there are no new federal funds as of September 30, 2007. If SCHIP is funded at current FFY2007 levels, California would have \$974 million available for FFY2008.

Scenario 1: No New Federal Dollars

It is possible, though not likely, that California will receive no new federal funding as of the end of the current FFY. Since California's SCHIP programs are estimated to spend \$1.24 billion in federal dollars for FFY2008,⁹ this would leave the state with less than two months of federal dollars, assuming no program changes, as shown in Table 2.

Table 2: SCHIP FFY2008 Federal Funding Impact, If No New SCHIP Dollars

Projected Annual Expenditures:	\$1,240,000,000
Funds Available (Per Table 1):	\$183,649,000
FFY2008 Projected Shortfall:	(\$1,056,351,000)
Months Until Funds Are Exhausted (Funds Available/Annual Expenditures):	1.8 months

Scenario 2: Flat Funding

If SCHIP is funded at FFY2007 levels, California would have a shortfall of approximately \$266 million, as shown in Table 3. The available funds would be enough to operate the state's existing SCHIP-funded programs for just over nine months, until about mid-summer 2008. This analysis projects that this cut-off would occur after the end of the state fiscal year on June 30, 2008.

Table 3: SCHIP FY2008 Federal Funding Impact, If Flat Funded

Projected Annual Expenditures:	\$1,240,000,000
Funds Available (Per Table 1):	\$974,438,213
FY2008 Projected Shortfall:	(\$265,561,787)
Months Until Funds Are Exhausted (Funds Available/Annual Expenditures):	9.4 months

Scenario 3: Interim Monthly Approach

It is also possible that Congress and the President agree to some level of interim funding while a broader compromise is developed. One scenario is that two months of the FFY07 federal allotment could be made available. Under this approach, California would be able to maintain

full enrollment based on the availability of California carryover funds and redistribution dollars, assuming new federal dollars will be made available. However, funding for future program operations would remain uncertain.

Scenario 4: Republican Proposal for a Short-Term Extension

Another scenario is a short term extension of SCHIP for 12 to 18 months while Congress and the President work toward a long-term compromise. Representative Joe Barton (R-Texas) has proposed extending SCHIP for 18 months in HR 3854. This bill expands the FFY2007 spending of \$5 billion by an additional \$1.5 billion for FFY2008 and \$1.1 billion for the first six months of FFY2009 to cover state shortfalls.

The \$1.5 billion in the bill is equal to the shortfall estimate from the Congressional Budget Office (CBO) of the funds needed for FFY2008 to maintain current programs.¹⁰ However, the estimate is based on conservative spending figures and may not leave much margin for error since the calculations assume no changes in eligibility rules or benefit packages after 2008.

It is not clear how much money California could receive under the Barton bill. Instead of using a set formula, the measure gives discretion to the Secretary of Health and Human Services to determine what, if any, shortfall each state has and allot the available dollars accordingly. No rules are provided as to how a shortfall is calculated.

Summary

With no new funding at all, California's SCHIP-funded programs could be forced to shut down by mid-November 2007. Under a flat-funding strategy, the shut-down could be postponed until the summer of 2008. Should Congress and the President agree to an interim monthly approach, the delay in full federal funding may force the state to limit Healthy Families enrollment as early as this fall, barring any changes in eligibility or other policy goals.

Methodology

This analysis builds on a May 2007 report published by the California HealthCare Foundation (CHCF), which found that California will need between \$1.16 and \$1.32 billion in federal support for SCHIP in FFY2008. In the calculations presented here, the midpoint estimate of \$1.24 billion is used.

In terms of estimated expenditures, several projections have been made with similar findings;¹¹ however this memo relies on findings in the May 2007 CHCF report.¹² The Managed Risk Medical Insurance Board (MRMIB) also has a budget projection that differs from the CHCF report by -1.2 percent.¹³ Note that any difference between SCHIP operations and the spending estimate would affect the length of time SCHIP programs could operate. For example, a faster rate of growth in enrollment than the spending estimate will reduce how long federal dollars will last.

Endnotes

¹ Peter Harbage et al, *The Future of California's SCHIP Program: Analyzing the Proposed Federal Legislation*, California HealthCare Foundation, July 2007.

² Ibid

³ California's Managed Risk Medical Insurance Board, Health Families Enrollment Report, August 20007. MRMIB May Budget Revise, 2007. Department of Health Services, May Budget Revise, May 2007.

⁴ Medi-Cal also uses Title XXI for prenatal care, though the number of woman benefiting from the program is undetermined.

⁵ Kaiser Daily Health Policy Report, "President Bush Vows To Veto SCHIP Expansion Legislation, Says Bill Puts Children's Health Coverage 'at Risk,'" September 21, 2007.

⁶ Assumes FFY2007 Title XXI allotment of \$791 million will be available in FY2008.

⁷ 2007 May Revision Federal Fund Chart, published by MRMIB.

⁸ Center for Budget and Policy Priorities SCHIP Financing Model, relying on the May 2007 spending projections and based on the reallotment formula in current law.

⁹ Peter Harbage et al, *Funding California's SCHIP Coverage: What Will It Cost?* California HealthCare Foundation, Working Paper, May 2007.

¹⁰ Congressional Budget Office, *Fact Sheet for CBO's March 2007 Baseline: State Children's Health Insurance Program*, February 23, 2007. Available online at: http://www.cbo.gov/ftpdocs/78xx/doc7861/m_m_schip.pdf.

¹¹ The Congressional Research Service, available at: http://www.opencrs.com/rpts/RS22712_20070828.pdf. The California Budget Project, available at www.cbp.org.

¹² Peter Harbage et al, *Funding California's SCHIP Coverage: What Will It Cost?*, California HealthCare Foundation, May 2007.

¹³ 2007 May Revision Federal Fund Chart, published by MRMIB.

**CALIFORNIA CODE OF REGULATIONS
TITLE 10. INVESTMENT
CHAPTER 5.8 MANAGED RISK MEDICAL INSURANCE BOARD
HEALTHY FAMILIES PROGRAM**

ARTICLE 2. ELIGIBILITY, APPLICATION, AND ENROLLMENT

Section 2699.6603 is amended to read:

2699.6603 2699.6602. **Early Applications.**

An applicant may apply to the program in advance for persons who are not eligible at the time of application, but who the applicant believes will become eligible within three (3) months because of one of the following:

- (a) They are currently enrolled in the Medi-Cal 200% Program and will become one year old.
- (b) They are currently enrolled in the Medi-Cal 133% Program and will become age 6.
- (c) They are currently on Medi-Cal for at least one month of continued eligibility under no cost, full scope Medi-Cal and have been notified by the county welfare office that coverage is ending.
- (d) It is anticipated that the child will be born. When the child is born, an applicant must submit documentation of the child's birth to the program, and must include the child's name, place and date of birth, and gender. The documentation and information must be received by the program within thirty (30) days from the birth for a child to be eligible pursuant to this section. Acceptable forms of documentation include a certificate of birth provided by a hospital or other health care facility, a signed statement by the health practitioner who presided over the delivery, or an equivalent document.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Sections 12693.21, 12693.70, Insurance Code.

Section 2699.6603 is added to read:

2699.6603. **Board Determinations.**

- (a) If the Board makes a finding that sufficient funds are not available to cover the estimated costs of program expenditures and that it is necessary to

limit enrollment in the program to ensure that expenditures do not exceed amounts available for the program, the program shall establish a waiting list.

- (b) If the Board makes a finding that sufficient funds are not available to cover the estimated cost of program expenditures and that, in addition to limiting new enrollment in the program, it is necessary to terminate subscribers in the program to ensure that expenditures do not exceed amounts available for the program, subscriber children shall be disenrolled from the program at the end of the month of their anniversary date following their Annual Eligibility Reviews. The program shall not effectuate disenrollments pursuant to this subsection unless it also has established a waiting list pursuant to (a) and is not currently enrolling additional children on the basis of new applications of Add-A-Person forms.
- (c) If the Executive Director determines that sufficient funds are available to cover the estimated cost of program expenditures for all eligible subscriber children, the program shall cease the disenrollment of eligible subscriber children pursuant to (b) during Annual Eligibility Review.
- (d) (1) If the Executive Director determines that in addition to sufficient funds for all eligible subscriber children, sufficient funds are available to cover the estimated cost of program expenditures for some or all children on the waiting list, the program shall review applications for children on the waiting list in the order of their effective dates on the waiting list.

(2) If the Executive Director determines that sufficient funds are available to cover the estimated costs of program expenditures, the program shall cease to operate a waiting list after processing the applications, including Annual Eligibility Review submissions, and Add-A-Person forms of all children on the waiting list.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Section 12693.21, and 12693.96 Insurance Code.

Section 2699.6604 is Added to Read:

2699.6604. Waiting List for Children.

- (a) If the program has established and is operating a waiting list pursuant to Section 2699.6603, children for whom the program has received applications or Add-A-Person forms shall be placed on the waiting list in the order their applications or Add-A-Person forms were received. A

child's effective date on the waiting list shall be the date on which the program received the child's application. An eligibility determination shall not be made until the Executive Director has made a determination pursuant to Section 2699.6603(d) and the applicant provides all supporting documentation pursuant to (d)(2).

- (b) If the Board makes a finding pursuant to Section 2699.6603(b), each subscriber child disenrolled at Annual Eligibility Review pursuant to Section 2699.6603(b) shall be placed on the waiting list and the subscriber child's effective date on the waiting list shall be his or her disenrollments date.
- (c) When the program places a child on the waiting list pursuant to (a) or (b), the program shall provide the applicant with written notification of the child's placement on the waiting list.
- (d) When the Executive Director determines, pursuant to Section 2699.6603(d), that sufficient funds are available to cover some or all eligible children who are not currently enrolled, the program shall enroll the number of eligible wait-listed children for whom sufficient funds are available, as follows:

 - (1) (A) The program shall first enroll those children who are on the waiting list because they were disenrolled at Annual Eligibility Review pursuant to Section 2699.6603(b). The program shall enroll these children in the order of their effective dates on the waiting list, starting with those who have the earliest effective date.

(B) If and when there are no remaining children who are on the waiting list because they were disenrolled at Annual Eligibility Review pursuant to Section 2699.6603(b), the program shall, to the extent that sufficient funds are available, enroll additional wait-listed children in the order of their effective dates on the waiting list, starting with those who have the earliest effective date.
 - (2) When sufficient funds are available to enroll a child based on that child's placement on the waiting list, the program shall provide the applicant with written notification. In that notice, the program shall request any necessary information pursuant to Sections 2699.6600 and 2699.6606 and any updates to information that no longer is current pursuant to Section 2699.6600. The program shall then make an eligibility determination in accordance with Sections 2699.6606 and 2699.6607 and shall enroll the child if he or she is eligible.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Section 12693.21, and 12693.96, Insurance Code

Section 2699.6605 is amended to read:

2699.6605. Initial Review of Application for Child-Linked Adults.

- (a) Upon receipt of an application or an Add a Person Application form, the program shall determine if there is funding available for additional enrollment of child-linked adults in the program.
- (b) (1) If there is no funding available for coverage of child-linked adults and the Board estimates that the program will be closed to new enrollment of child-linked adults for less than six (6) consecutive weeks, applications will be reviewed for completeness as set forth in Section 2699.6606 below and if complete, for eligibility. For persons age 19 and over who are determined to be eligible, the program will retain the applicant's family parent contributions payment to use to enroll the eligible child-linked adult(s) in the program once a vacancy opens in the program. The applicant may request a refund of the family parent contributions payment but the child-linked adult for whom enrollment was requested will be removed from the program waiting list. Persons age 19 and over for whom application is being made who are determined to be eligible will be placed on a waiting list in the following categories:
 - (A) Child-linked adults with an annual household income after income deductions of up to and including 100 percent of the federal poverty level.
 - (B) Child-linked adults with an annual household income after income deductions greater than 100 percent and up to and including 150 percent of the federal poverty level.
 - (C) Child-linked adults with an annual household income after income deductions greater than 150 percent and up to and including 200 percent of the federal poverty level.
- (2) The waiting list will be maintained as follows:
 - (A) Child-linked adults in category (b)(1)(B) will be placed ahead of child-linked adults in category (b)(1)(C) on the waiting list.

Child-linked adults in category (b)(1)(A) will be placed ahead of child-linked adults in category (b)(1)(B) on the waiting list.

- (B) Within each category, persons for whom application is being made who are determined to be eligible will be listed in the order in which completed applications were received by the program.
 - (C) Each applicant shall be notified of placement on the waiting list. When a vacancy occurs or funds become available, whichever is applicable, persons for whom application is being made shall be enrolled in the order in which they appear on the waiting list.
- (c) If there is no funding available and the Board estimates that the program will be closed to new enrollment for six (6) consecutive weeks or more for child-linked adults, the program will so notify applicants on behalf of child-linked adults. The program will apply the family parent contributions to the family child contributions for that household unless the applicant requests a refund of the family parent contributions. The program shall refund the applicant's family parent contributions if there is no subscriber child in the household. When funds become available, the program will notify these applicants that the program is opening for new enrollment. To request coverage when the program opens for new enrollment, an applicant who previously applied for enrollment for a childlinked adult when the program was closed to new enrollment for six (6) consecutive weeks or more will be required to submit a new application pursuant to Section 2699.6600.
- (d) If there is funding available, or there is no funding available for coverage of child-linked adults but the Board estimates that the program will be closed to such new enrollment for less than six (6) consecutive weeks, the application shall be reviewed for completeness pursuant to Section 2699.6606.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code.
Reference: Sections 12693.21 and 12693.755, Insurance Code.

Section 2699.6608 is amended to read:

2699.6608 Enrollment of AIM Infants.

- (a) An AIM infant, who is born prior to July 1, 2007, shall be enrolled without application when the program receives the required family child contribution beginning with the first full month of coverage pursuant to

Section 2699.6613(g), and the following information about the infant from the AIM infant's mother at any time through the end of the eleventh month following the month of birth:

- (1) Name; and
 - (2) Date of birth; and
 - (3) Sex.
- (b) An AIM infant, who is born on or after July 1, 2007, shall be enrolled without application provided the infant is not enrolled in no-cost full scope Medi-Cal, meets the eligibility requirements pursuant to Subsection 2699.6607(d), and the following information about the infant from the AIM infant's mother is provided at any time through the end of the eleventh month following the month of birth. Coverage shall begin pursuant to Subsection 2699.6613(h).
- (1) Name; and
 - (2) Date of birth; and
 - (3) Sex; and
 - (4) Information on whether or not the infant currently is enrolled in employer sponsored health coverage and the date coverage began; and
 - (5) Information on whether or not the infant was previously enrolled in employer sponsored health coverage, the date coverage began, the date in which coverage terminated, and the reason for termination.
- (c) The program shall request information from the AIM infant's mother, on the AIM infant's weight at birth and primary care provider.
- (d) In lieu of reporting by the AIM infant's mother, the program must also accept the information specified in subsections (a) and (c) from the AIM infant's mother's health plan or a health care provider that provided services to the AIM infant's mother or the AIM infant.
- (e) Upon receipt of the family child contribution and the information specified in subsection (a), or the information as specified in subsection (b), the program shall automatically enroll the eligible infant in the same health

plan within the Healthy Families Program that the AIM infant's mother is enrolled in through the AIM program.

- (f) Automatic enrollment of AIM infants (born before July 1, 2007) is subject to payment of family child contributions and timely notification of the infant's birth as provided in (a).
- (g) Enrollment of eligible AIM infants (born on or after July 1, 2007) is subject to timely notification of the infant's birth as provided in (b).
- (h) Notwithstanding subsection (a) or (b) of this section, infants in need of immediate health care services will be immediately enrolled in the program if: (1) the AIM infant's mother's health plan notifies the program in writing of the need for services and provides the information specified in subsection (a) or (b) of this section; and (2) this written notification occurs no later than the 10th day of the second full calendar month of the infant's life. For infants enrolled pursuant to this subsection (h), the required family child contribution shall be billed to the AIM mother. If the required family child contribution is not paid, the provisions of this article concerning disenrollment for failure to pay the required family child contribution shall govern.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code.
Reference: Sections 12693.21, 12693.70, 12693.71, 12693.73 and 12693.755 and 12693.765, Insurance Code.

Section 2699.6611 is amended to read:

2699.6611. Disenrollment.

- (a) A subscriber shall be disenrolled from participation in the program if any of the following occur:
 - (1) The subscriber is found by the program to no longer be eligible during the annual eligibility review period.
 - (2) The Board has made a finding pursuant to Section 2699.6603(b) and subscriber children are disenrolled from the program at Annual Eligibility Review. Each subscriber child disenrolled pursuant to Section 2699.6603(b) shall be placed on the waiting list and the subscriber child's effective date on the waiting list shall be his or her disenrollment date.
 - ~~(2)~~(3) The subscriber child attains the age of 19. A subscriber child who

attains the age of 19 will not be disenrolled from the program if he or she applies to the program pursuant to Section 2699.6600 and is determined to be eligible for the program as a subscriber parent pursuant to Section 2699.6607 before his or her effective date of disenrollment.

- ~~(3)~~(4) A subscriber is determined by the program to not be a citizen, non-citizen national, or a qualified alien eligible to participate in the program or fails to provide documentation required pursuant to Subsection 2699.6600(c)(1)(T) within the required time period.
- ~~(4)~~(5) The applicant fails to pay the required family contribution for the subscriber for two (2) consecutive calendar months.
- ~~(5)~~(6) The applicant so requests in writing on behalf of himself or herself or on behalf of another subscriber for whom he or she applied.
- ~~(6)~~(7) The applicant has intentionally made false declarations in order to establish program eligibility for any person.
- ~~(7)~~(8) The applicant fails to provide the necessary information for the subscriber to be requalified.
- ~~(8)~~(9) Death of a subscriber.
- ~~(9)~~(10) The child through whom the subscriber parent became eligible as a child-linked adult as defined in Section 2699.6500 is no longer enrolled in no-cost Medi-Cal and has not enrolled in the program.
- ~~(10)~~(11) The child through whom the subscriber parent became eligible as a child-linked adult as defined in Section 2699.6500 did not enroll in no-cost Medi-Cal, or the program, and the subscriber parent has no other children enrolled in the program or no-cost Medi-Cal.
- ~~(11)~~(12) The child through whom the subscriber parent became eligible as a child-linked adult as defined in Section 2699.6500 attains the age of 19 and the subscriber parent has no other children enrolled in the program or no cost Medi-Cal.
- ~~(12)~~(13) The child through whom the subscriber parent became eligible as a child-linked adult as defined in Section 2699.6500 no longer lives with the subscriber parent and another adult with whom the child now lives applies and is found eligible for enrollment as a child-linked adult through the same child.

- ~~(13)~~(14) The child through whom the subscriber parent became eligible as a child-linked adult as defined in Section 2699.6500 is no longer enrolled in the program, and the subscriber parent has no other children enrolled in the program or no-cost Medi-Cal.
- (b) (1) Prior to disenrolling a subscriber pursuant to ~~(a)(4)~~(5), the program shall provide written notification to the applicant no less than thirty (30) days prior to disenrollment. Such notice shall clearly indicate all of the following:
- ~~(4)~~(A) The disenrollment will not occur if payment in full is made as required.
- ~~(2)~~(B) If disenrollment for non-payment occurs, coverage will be terminated at the end of the second consecutive month for which the family contribution was not paid.
- (2) Prior to disenrolling a subscriber pursuant to (a)(2), the program shall provide written notification to the applicant no less than fifteen (15) days prior to disenrollment. Such notice shall clearly indicate all of the following:
- (A) The reason for the disenrollment.
- (B) The effective date of disenrollment.
- (c) When a subscriber is disenrolled pursuant to (a) above, the program shall notify the applicant of the disenrollment. The notice shall be in writing and include the following information:
- (1) The reason for the disenrollment.
- (2) The effective date of disenrollment.
- (3) The final day of coverage provided through the program.
- (4) An explanation of the appeals process including the right to request continued enrollment pursuant to Section 2699.6612.
- (d) Disenrollment pursuant to ~~(a)(4)~~(5) shall be effective as of the end of the second consecutive calendar month for which the required monthly contributions were not paid in full.

- (e) Disenrollment pursuant to (a)(1), (a)(2) and (a)(7)(8) shall be effective at the end of the month of the subscriber's anniversary date.
- (f) Disenrollment pursuant to (a)(3)(4) shall be effective at the end of the calendar month in which the conclusion of the two-month period falls pursuant to Subsection 2699.6600(c)(1)(T).
- (g) Disenrollment pursuant to (a)(5)(6) shall be effective at the end of the month in which the applicant's request was received. The applicant will be notified of the amount of family contribution due to the program for coverage through the subscriber's effective date of disenrollment.
- (h) Disenrollment pursuant to (a)(6)(7) shall be effective at the end of the month in which the determination was made.
- (i) Disenrollment pursuant to (a)(2)(3) and (a)(11)(12) shall be effective on the last day of the month the subscriber child or the child through whom the subscriber parent became eligible as a child-linked adult attains the age of 19.
- (j) Disenrollment pursuant to (a)(8)(9) shall be effective at the end of the month in which death occurred.
- (k) Disenrollment pursuant to (a)(9)(10) shall be effective at the end of the month following the program's notification of the subscriber child's disenrollment from no-cost Medi-Cal.
- (l) Disenrollment pursuant to (a)(10)(11) shall be effective at the end of the month following the second month from the date in which the application was received.
- (m) Disenrollment pursuant to (a)(12)(13) shall be effective at the end of the month following the program's determination that the subscriber child has departed from the subscriber parent's household and is living with another adult who has applied for enrollment and is eligible as a child-linked adult through that same child.
- (n) Disenrollment pursuant to (a)(13)(14) shall be effective at the end of the month following the program's determination that the adult is no longer child linked.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code.
Reference: Sections 12693.21, 12693.45, 12693.74, 12693.77, 12693.755, 12693.96, 12693.98 and 12693.981, Insurance Code.

Section 2699.6625 is amended to read:

2699.6625. Annual Eligibility Review for Subscribers.

- (a) Except as specified in (c), each subscriber will be re-evaluated annually prior to his or her anniversary date in the program to determine continued eligibility for the program. Applicants shall be notified of the annual eligibility review process at least sixty (60) calendar days prior to the anniversary date.
- (b) Notwithstanding (a), as a condition of continuing coverage beyond the age of twelve (12) months, an applicant who enrolls an AIM infant into the program after nine months of age shall provide the information necessary to determine the infant's eligibility for ongoing coverage after the age of twelve (12) months at the time of enrollment.
- (c) If subscribers for whom an applicant has applied have different anniversary dates, the annual eligibility review will be based on the anniversary date of the last subscriber to be enrolled, except as described in Subsection 2699.6631(f).
- (d) To requalify, an applicant must provide to the program all of the following information which is required to reestablish eligibility: the applicant's name and account number as stated on their billing statement; name and address of each enrolled person, documentation of gross income of each enrolled person's household as described in Subsection 2699.6600(c)(1)(K), documentation of court ordered child support, and/or alimony paid, and child care and/or disabled dependent care expenses paid in order to determine income deductions as described in Subsection 2699.6600(c)(1)(L), an indication of any pregnant family member living in the home and her expected due date, and a statement indicating which person(s) is currently enrolled in an employer sponsored health insurance plan. To avoid a break in coverage, all required information must be submitted at least ten (10) calendar days before the end of the month in which the anniversary date falls.
- (e) Continued eligibility will be determined pursuant to Sections 2699.6607- and 2699.6611(a)(2).
- (f) Unless disenrolled pursuant to Section 2699.6611, persons shall continue to be considered eligible for the program for one year from the effective date of coverage, or if a later annual eligibility review date is established under (c), until that date.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Sections 12693.21, 12693.74, and 12693.96, Insurance Code.